Medical Records Release Consent for Critical Illness Assessment

I hereby authorize the release, exchange, or disclosure of my medical records and information by healthcare providers, hospitals, clinics, and insurers to the designated medical assessors and insurance representatives for the purpose of critical illness assessment and benefit determination.

This consent includes any information relating to my diagnosis, treatment, medical history, hospitalization, consultations, test results, and all other relevant medical data required for the assessment of my critical illness claim.

I understand that this release is voluntary, and that refusal to sign may affect my claim assessment. I understand that my information will be used solely for the purposes of evaluating my eligibility for benefits related to critical illness.

This authorization shall remain valid for one (1) year from the date of signature unless revoked by me in writing prior to that time.

Full Name of Patient:

Date of Birth:

ID/Policy Number:

Contact Number:

Name of Healthcare Provider(s):

Recipient of Medical Information

Name of Assessor/Insurer:

Purpose of Release:

Signature of Patient/Legal Representative

Date

Name of Legal Representative (if applicable)

Relationship to Patient

A copy of this authorization is as valid as the original.